DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems. From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0 percent, 98.5 percent, and 98.0 percent respectively of their Medicare Part B Physician Fee Schedule (PFS) amount for covered professional services. CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship. To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communications Support Page) on or between March 1 and June 30, 2012.

MLN Matters® Number: MM7834

Related Change Request (CR) #: 7834

Related CR Release Date: May 25, 2012

Effective Date: August 27, 2012

Related CR Transmittal #: R2477CP

Implementation Date: August 27, 2012

Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7834, which advises you that the Centers for Medicare & Medicaid Services (CMS) is revising the "Medicare Claims Processing Manual" to specify that, if a provider, supplier, or beneficiary is unable to provide the Medicare contractor with an official Social Security Administration (SSA) letter, the contractor must check the Common Working File (CWF) database in order to verify a beneficiary's retroactive Medicare entitlement date. Be sure that your staffs are aware of this change.

Background

The Medicare regulations at 42 Code of Federal Regulations (CFR), Section 424.44, specify the time limits for filing Part A and Part B Fee-For-Service claims. Section 424.44 also identifies certain exceptions to the claims filing time limit. If the requirements for satisfying a timely filing exception are met, an extension to file the claims may be granted.

Section 6404 of the Affordable Care Act reduced the maximum period for the submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date a service is furnished. Section 6404 also gave the Secretary of Health and Human Services the authority to create exceptions to the 12 month timely filing limit. As a result of this legislation, revisions were made to the timely filing regulations at 42 CFR, Section 424.44, and the relevant internet-only manual sections. (See Transmittal 2140/Change Request 7270, published on January 21, 2011, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads//R2140CP.pdf, on the CMS website.)

The "Medicare Claims Processing Manual" currently requires that, in order to be granted a timely filing extension, the provider, supplier, or beneficiary must furnish an official letter from the SSA to the beneficiary in order to meet one of the conditions that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service. The purpose of CR 7834 is to revise sections 70.7, 70.7.2, and 70.7.3 of the manual to specify that, if an official SSA letter to the beneficiary is not submitted, Medicare contractors must check the CWF database and may interpret the CWF data in order to verify that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service.

Consequently, CR 7834 requires the Medicare contractors to accept the SSA letter or, in the absence of such letter, to check the CWF database for a beneficiary's date of Medicare entitlement. Contractors may interpret the CWF data in order to verify retroactive Medicare entitlement that may permit a claim to be processed after the 12 month timely filing limit.

Additional Information

The official instruction, CR7834, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2477CP.pdf on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.